20-P-467 Appeals Court

IN THE MATTER OF M.S.

No. 20-P-467.

Berkshire. November 3, 2020. - February 25, 2021.

Present: Wolohojian, Milkey, & Sullivan, JJ.

Incompetent Person, Commitment, Consent to medical treatment. Practice, Civil, Commitment of mentally ill person. Witness, Psychiatric examination. Doctor, Privileged communication. Evidence, Privileged communication. Privileged Communication.

Petitions for civil commitment and to authorize medical treatment filed in the Pittsfield Division of the District Court Department on December 21, 2016.

The petitions were heard by William A. Rota, J.

Melanie S. Lewis for the respondent.
Jennifer Galvagni Carpenter for the petitioner.

MILKEY, J. On one day in 2016, Berkshire Medical Center filed two petitions with regard to its patient M.S., an adult woman. The first sought M.S.'s involuntary commitment, and the second sought authority to administer her antipsychotic

medication without her consent (Rogers order). See Rogers v. Commissioner of the Dep't of Mental Health, 390 Mass. 489 (1983). A District Court judge granted both petitions after holding back-to-back evidentiary hearings. Before us now is M.S.'s appeal of the Appellate Division of the District Court Department's affirmance of the Rogers order.[1] As explained below, the critical issue in M.S.'s appeal is her claim that the judge improperly considered evidence subject to the psychotherapist-patient privilege established by G. L. c. 233, § 20B. We affirm the decision and order of the Appellate Division.

Background. The first of the two back-to-back hearings addressed the commitment petition that the hospital filed pursuant to G. L. c. 123, §§ 7, 8. The hospital presented one witness, Dr. Anthony Giovanone, the psychiatrist who had treated M.S. for the previous three-plus years. Dr. Giovanone diagnosed M.S. as suffering from schizoaffective disorder, bipolar type. He explained in detail how this disorder manifested in terms of psychosis, auditory hallucinations, paranoid delusions, and disordered and grandiose thinking. As Dr. Giovanone put it,

[1] M.S. appealed both the commitment order and the Rogers order to the Appellate Division, and subsequently filed an appeal from the decision and order of the Appellate Division affirming both orders. On appeal, however, M.S. pursues only the appeal from the Rogers order.

M.S. was unable to determine "what was real and what wasn't." According to him, M.S.'s "paranoid delusions [in turn] make it hard for her to trust the treatment team," and even when she agreed to a plan of medication, she was noncompliant. As a result, Dr. Giovanone saw her mental condition deteriorating. He also testified as to the dates and duration of some of her numerous prior hospital admissions, and that she had attacked someone during one prior admission. Dr. Giovanone recounted the perils that led to some of her earlier hospitalizations. One followed a period when she lived in the New York City subway system during which she reported that she was shot; another followed an incident when the police had to employ search dogs to track her down in the middle of the woods. Dr. Giovanone feared that if M.S. were released, she would "end up either in the woods again in the winter . . . [o]r . . . back in the subway, without any money, food, just waiting to either die or hopefully be found again." It is not clear how much of the doctor's testimony was based on confidential communications from M.S., as opposed to his own observations or other sources (such as medical records and police reports).

M.S. testified on her own behalf, and her testimony undermined her defense. For example, she testified that the hospital allowed "gang members" into her ward "overnight, who get the keys to [her] rule book and use it to take creative

evidence from [her]." According to her, another gang of men had raped her, "looking to go after [her] quarter of a trillion dollars in musical, intellectual property." She also testified that since she had stopped taking medications ten days prior, she "ha[d] exhibited happy, joyous behavior." She disclaimed reliance on her father, whom she explained planned to prostitute her, while providing only the vaguest testimony about how unspecified people "waiting in Berkshire County" would keep her safe. She acknowledged that her living "in the subway . . . ended rather poorly." Thus, much of M.S.'s own testimony -- none of which was protected by privilege -- overlapped with, or otherwise reinforced, the testimony of Dr. Giovanone. At the conclusion of M.S.'s testimony and closing arguments by both counsel, the judge announced that he had concluded that the hospital had met its burden of proof and that he would issue a commitment order.

The second hearing -- to address the petition that the hospital filed pursuant to G. L. c. 123, § 8B, seeking a Rogers order -- began immediately after the first. Just before the § 8B hearing began, the judge addressed M.S. directly, stating, "[W]e have more to do, if you'd like to remain." He then added: "You're welcome to leave if you wish. All right. Thank you very much. For the record, she's left the room." We agree with the Appellate Division that, read in context, the judge very

likely reacted to the fact that M.S. started to leave as the second hearing began, not -- as M.S. suggests -- that the judge sua sponte invited her to leave. In any event, M.S.'s lawyer stayed and lodged no objection going forward without her.

Only Dr. Giovanone testified during the second phase of the hearing. At the outset, the judge directed that "[t]he issue now is whether or not [M.S.] should be medicated against [M.S.'s] will." Similarly, immediately before cross-examination began, the judge directed [M.S.'s] counsel to cross-examine "on the limited issue of medication." Accordingly, Dr. Giovanone's testimony focused on the potential benefits and detriments of the hospital's specific proposed treatment plan. The hospital did not solicit new testimony from Dr. Giovanone on direct examination regarding M.S.'s mental illness or her inability to manage her medical affairs, but instead effectively treated those issues as already having been established by the evidence presented at the first hearing. This is well illustrated by the initial question that the hospital's counsel posed: "Dr. Giovanone, you've already testified that [M.S.] suffers from schizoaffective disorder. With regard to medication, what treatment do you believe is necessary?" At one point in response to a question on cross-examination regarding M.S.'s expressed preferences, Dr. Giovanone volunteered, "I don't think [M.S. is] capable of . . . weighing the risks and benefits at

this time." M.S.'s counsel moved to strike this as unresponsive. The judge declined to do so, observing, "[T]hat's the very issue we're addressing, whether if she were competent -- whether she's currently competent and whether she would -- if she were competent, she would make that decision."

In ruling in the hospital's favor, the judge found that "[b]ecause of her mental illness, [M.S.] lacks insight into her mental illness, and is incompetent to make informed decisions about her medical treatment with anti[]psychotic medications." After finding that M.S. would have consented to the hospital's proposed treatment plan if she had been competent, the judge also approved the treatment plan.

On appeal, the Appellate Division ruled that "the evidence that was introduced in the course of the § 8B hearing dealt solely with the adjudication of substituted judgment and potential treatment." According to the Appellate Division, "[n]o evidence was introduced [during the § 8B hearing] regarding the question of whether M.S. was incapable of making informed decisions about proposed medical treatment." Nevertheless, the Appellate Division affirmed the Rogers order based on evidence that had been submitted during the first hearing. As the panel put it, "a judge who issues an order for commitment following a hearing under G. L. c. 123, §§ 7 and 8[,]

may consider the evidence he or she just heard in a § 8B hearing that immediately follows."

Discussion. 1. Mootness. The Rogers order ran concurrently with the commitment order, which expired after six months. Thus, the order under appeal is no longer in effect. Moreover, the hospital has represented that M.S. remains subject to a subsequently-issued Rogers order, which is not before us, that arose out of a separate Probate and Family Court proceeding. Under these circumstances, the hospital maintains that the current appeal is moot. M.S. disagrees, relying predominantly on Matter of F.C., 479 Mass. 1029, 1029-1030 (2018), quoting Seney v. Morhy, 467 Mass. 58, 62 (2014) (appeals from expired Rogers orders "should not be dismissed as moot where the parties have a continuing interest in the case," including with respect to "removing a stigma from [her] name and record"). We pass over the question of mootness and conclude that, in any event, M.S.'s arguments on appeal do not succeed for reasons specific to the current record.

2. Merits. As an initial matter, we note our disagreement with the Appellate Division's assessment that there was "[n]o" evidence presented at the § 8B hearing with respect to M.S.'s capacity to make informed decisions concerning her medical care. As noted, Dr. Giovanone specifically testified regarding M.S.'s ability to "weigh[] the risks and benefits" of her treatment

options. Nevertheless, we agree with the panel's overall conclusion that the validity of the Rogers order depended in part on evidence that was admitted during the commitment hearing. Such evidence included, for example, Dr. Giovanone's testimony that M.S. suffered from schizoaffective disorder, bipolar type.

We further agree with the Appellate Division's conclusion that at least where the § 8B hearing follows on the heels of the commitment hearing,[2] there was no obligation for the judge sua sponte to put out of mind the evidence that had been presented at the just-concluded commitment hearing. Moreover, absent a timely assertion of a privilege, or other circumstances not present here, judicial economy and the interest in prompt resolution in a case, such as this one, favor not requiring witnesses to testify twice on the same day to the same points they just covered. In reaching this conclusion, we recognize that § 8B (b) commands that "[a] petition filed under this section [that is, a Rogers petition] shall be separate from any pending petition for commitment and shall not be heard or otherwise considered by the court unless the court has first issued an order of commitment on the pending petition for

[2] Where, as here, the commitment and Rogers petitions are filed on the same day, the § 8B hearing must begin on the same day as the commitment hearing. See G. L. c. 123, § 8B (c).

commitment." Certainly, such language evinces a legislative intent that a judge consider the Rogers issues separate from, and only after, addressing the issues raised by the commitment petition. However, especially given the statutory requirement that the § 8B hearing begin the same day as the commitment hearing, we do not interpret the just-quoted language as requiring the presiding judge to wipe the slate clean of all evidence that is pertinent to both proceedings at the conclusion of the first hearing.

Nonetheless, M.S. has identified one significant respect in which the introduction and use of evidence at commitment hearings and § 8B hearings may differ. The possible difference involves the psychotherapist-patient privilege created by G. L. c. 233, § 20B. Per an express exemption in that statute, the privilege may not be invoked in commitment hearings.[3] See Walden

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[3] The relevant exemption states as follows:

> "If a psychotherapist, in the course of his diagnosis or treatment of the patient, determines that the patient is in need of treatment in a hospital for mental or emotional illness or that there is a threat of imminently dangerous activity by the patient against himself or another person, and on the basis of such determination discloses such communication either for the purpose of placing or retaining the patient in such hospital, provided however that the provisions of this section shall continue in effect after the patient is in said hospital, or placing the patient under arrest or under the supervision of law enforcement authorities."

G. L. c. 233, § 20B (a).

Behavioral Care v. K.I., 471 Mass. 150, 153-154 (2015). M.S. argues, with at least some force, that this exemption does not apply with regard to evidence to be considered in the context of a Rogers petition. Strengthening this position is the fact that § 8B, which governs Rogers petitions, includes its own language regarding the applicability of the psychotherapist-patient privilege in that context. That language states:

> "Any privilege established by [G. L. c. 112, § 135, governing the social worker-client privilege] or by [G. L. c. 233, § 20B, governing the psychotherapist-patient privilege], relating to confidential communications, shall not prohibit the filing of reports or affidavits, or the giving of testimony, pursuant to this section, for the purpose of obtaining treatment of a patient, provided that such patient has been informed prior to making such communications that they may be used for such purpose and has waived the privilege."

G. L. c. 123, § 8B (h). Based on this language, M.S. argues that while communications between patients and their psychotherapists can be waived with respect to a Rogers petition, such a waiver can occur only where the psychotherapist had provided the patient a prior warning that any statements could be used against the patient in such a proceeding. According to M.S., the judge violated M.S.'s statutory right to exclude privileged communications without her consent by allowing the hospital to rely on the testimony that Dr. Giovanone gave at the commitment hearing, without the hospital having demonstrated that Dr. Giovanone had provided M.S. the

necessary warnings before such communications were made, and without regard to whether M.S. thereafter had waived her privilege.

M.S. did not raise the confidentiality of her communications with Dr. Giovanone at any point in the proceedings before the judge. Nor did M.S. object to the manner in which the Rogers hearing was conducted, or to the judge considering in that context the testimony that had been given in the just-completed commitment hearing. Rather, M.S. treated the two hearings as two phases of a unified hearing, for example, by submitting her proposed findings and rulings with regard to the Rogers issues before Dr. Giovanone began his testimony in the § 8B hearing.[4]

The psychotherapist-patient privilege is a creature of statute, and "is not self-executing." Commonwealth v. Oliveira, 438 Mass. 325, 331 (2002). Rather, "[t]he patient must therefore affirmatively exercise the [G. L. c. 233, § 20B,] privilege in order to prevent the psychotherapist from disclosing confidential communications at trial." Id., quoting P.J. Liacos, M.S. Brodin, & M. Avery, Massachusetts Evidence

[4] That fact undercuts M.S.'s claim that the lack of formal notice that evidence admitted in the commitment hearing could be used in the Rogers hearing violated her due process rights. In addition, with the exception of the privilege issues that we address at length, M.S. has not demonstrated how she potentially was prejudiced.

§ 13.5.2, at 796 (7th ed. 1999). Accord Commonwealth v. Pickering, 479 Mass. 589, 595 (2018); Adoption of Abigail, 23 Mass. App. Ct. 191, 198 (1986) ("No effort was made to [assert the psychotherapist-patient privilege in the trial court], and the privilege issue cannot now be raised as a second thought of appellate counsel"). Where M.S. did nothing in the trial court to assert her claim of privilege, her ability to do so now stands in at least serious doubt.

In any event, our review of these unpreserved issues would at most be limited to whether any errors caused a substantial risk of a miscarriage of justice. See Matter of Laura L., 54 Mass. App. Ct. 853, 856, 861 (2002) (applying substantial risk of miscarriage of justice standard to unpreserved claim that privileged communications were improperly used in civil commitment proceeding conducted pursuant to G. L. c. 123, § 12). Cf. R.B., petitioner, 479 Mass. 712, 715-718 (2018) (applying substantial-risk standard to unpreserved error in context of sexually dangerous person proceeding). That standard "requires us to determine 'if we have a serious doubt whether the result of the trial might have been different had the error not been made.'" Commonwealth v. Azar, 435 Mass. 675, 687 (2002), quoting Commonwealth v. LeFave, 430 Mass. 169, 174 (1999). M.S. has the burden of making such a showing. Cf. Commonwealth v. Robinson, 83 Mass. App. Ct. 419, 427 (2013). In our view, she

has not carried her burden on the current limited record even if we assume arguendo that her interpretation of the statute is correct.

Like other testimonial privileges, the psychotherapist-patient privilege is an "exception[] to the general duty imposed on all people to testify and therefore must be strictly construed" (quotations and citation omitted). Walden Behavioral Care, 471 Mass. at 154. Also like other testimonial privileges, the psychotherapist-patient privilege protects communications. Id. at 153 & n.5, quoting G. L. c. 233, § 20B. It generally does not prevent a treating psychiatrist from passing along his diagnosis of a patient so long as that diagnosis does not reveal communications. See Adoption of Saul, 60 Mass. App. Ct. 546, 552-553 (2004) (treating psychiatrist's diagnosis of patient's condition that did not reveal confidential communications was not privileged). In Adoption of Saul, we expressly rejected the patient's argument that the diagnosis of schizoaffective disorder itself was privileged "because any diagnosis as to the nature of her mental illness could not have been made absent communications to her psychotherapist in the course of treatment or diagnosis." Id. at 550.[5] A psychotherapist's observations of

[5] In Adoption of Saul, 60 Mass. App. Ct. at 549, the claim that the psychotherapist-patient privilege applied was fully preserved.

his patient's behavior that do not encompass communications are also not privileged. See Adoption of Abigail, 23 Mass. App. Ct. at 198-199. Nor are the facts or dates of hospital admissions privileged. Commonwealth v. Clancy, 402 Mass. 664, 667 (1988).

With such principles in mind, we conclude that the extent to which Dr. Giovanone might have revealed privileged communications is far from apparent on the record before us.[6] This is unsurprising. Because M.S. never invoked the privilege before or during the proceedings, the facts were never developed with attention to that issue. See Oliveira, 438 Mass. at 333 (privilege is not self-executing in part because applying it properly requires factual development). In any event, M.S.'s own counterproductive testimony provided robust evidence of her mental state and prognosis.

In analyzing whether the disclosure of privileged communications may have changed the outcome of the hospital's petition, the question is whether the judge relied on such

[6] The case law leaves somewhat open just how revealing a doctor's overall observations and prognosis must be of the underlying communications to involve the privilege. Compare Adoption of Saul, 60 Mass. App. Ct. at 552 nn.7, 8, with Department of Youth Servs. v. A Juvenile, 398 Mass. 516, 520, 526 (1986) (excluding general prognosis as revealing of privileged communications). We need not resolve this question to decide this case.

testimony, not whether he heard it.[7] We presume that the judge properly instructed himself "absent contrary indication" (citation omitted). Commonwealth v. Kerns, 449 Mass. 641, 650 n.13 (2007). We see no contrary indication here.[8] In light of this principle, and of the limited record before us, we conclude that M.S. has not demonstrated a substantial risk of a miscarriage of justice.[9]

One remaining issue warrants further discussion. We recognize that M.S. has sought to raise potentially important legal questions regarding how the psychotherapist-patient

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[7] M.S. acknowledges that there was no error in otherwise privileged communications being admitted during the commitment hearing. Thus, even under M.S.'s own interpretation of the law, the judge would have to disregard evidence he may have heard to decide the Rogers issues.

[8] Given that the privilege is not self-executing, the apparent lack of judicial inquiry into the application of the privilege is not itself a contrary indication. Cf. Pickering, 479 Mass. at 595.

[9] M.S.'s remaining arguments are not persuasive. The evidence taken as a whole was ample to support the judge's findings, and we are unpersuaded by her argument that the judge's findings were insufficiently detailed. Contrast Matter of R.H., 35 Mass. App. Ct. 478, 484-486 (1993). Indeed, the level of specificity included in the judge's findings was comparable to those in M.S.'s own proposed findings.

M.S. additionally argues that before she walked out of the hearing, the judge was obligated to conduct a formal colloquy establishing that she knowingly and voluntarily was giving up her right to be present. She cites to no case law establishing such an obligation, and, in any event, we decline to find that the absence of any such a warning caused a substantial risk of a miscarriage of justice in this case.

privilege is to operate when a treating psychiatrist determines that his or her patient needs antipsychotic drugs but is unwilling to take them. Whether or not she prevails in the current appeal, M.S. has urged us to adopt her interpretation of the statutory framework instead of merely assuming it arguendo. We decline to do so. In addition to the general norm that appellate courts should resolve cases on the narrowest ground possible, there are at least three reasons why the current case does not provide a suitable vehicle to resolve the issues M.S. has raised.

First, the parties have inadequately developed the legal issues, such as how the statutory text should be parsed. For example, neither party has adequately addressed the text of G. L. c. 123, § 8B (h), and how it differs from the statutory provision at issue in Commonwealth v. Lamb, 365 Mass. 265, 266, 269-270 (1974) (psychotherapist-patient privilege bars use of communications between court-appointed psychiatrist and respondent in sexually dangerous person proceeding unless, per G. L. c. 233, § 20B (b), respondent is first informed that such communications would not be privileged).[10] Nor has either party addressed the issue of whether otherwise privileged

[10] While it is true that the warning language included in § 8B (h) bears some resemblance to that of the statutory provision considered in Lamb, the language is not identical.

psychotherapist-patient communications lose that privilege once their confidentiality has been breached through their proper admission in a commitment hearing. Cf. Commonwealth v. Waweru, 480 Mass. 173, 183 (2018) ("Unlike many other States that require the communication to be confidential or not intended for further disclosure, the Commonwealth has no such requirement in the text of G. L. c. 233, § 20B").

Second, the parties have not addressed how M.S.'s interpretation would or would not work in practice. In the context of a court-ordered psychiatric evaluation -- where the very purpose of the psychotherapist-patient relationship is to generate evidence to be used in an adversarial legal proceeding -- a Lamb warning serves a straight-forward role: to let the respondent know that any communications made in this context would not be privileged. Lamb, 365 Mass. at 269. Requiring that such warnings be given by treating psychotherapists at a time when no adversarial litigation is contemplated would raise a number of practical complications, including, for example, with regard to determining whether, once warned, the patient has waived the issue of privilege.[11]

[11] By command of the statute creating the psychotherapist-patient privilege, "[i]f a patient is incompetent to exercise or waive such privilege, a guardian shall be appointed to act in his behalf under this section." G. L. c. 233, § 20B.

Third, as discussed above, the record does not reveal how much this case actually implicated privileged communications. See Matter of Laura L., 54 Mass. App. Ct. at 857-861. For all of these reasons, prudence dictates that we leave the statutory interpretation issues that M.S. has sought to raise to be resolved another day, on a more fully developed record. In the interim, we encourage judges and practitioners to consider these issues carefully in future Rogers proceedings, and patients seeking to assert a privilege should do so as early as possible in the process.

Conclusion. We affirm the decision and order of the Appellate Division.

So ordered.